Podcast Series: Heart Failure Podcast Series

Episode Title: **Obesity Across the Spectrum on Heart Failure: Who Do We Treat & How?**

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00:00:09.450 --> 00:00:19.410
Celeste Chavez: Welcome to the American Heart Association's Heart Failure Podcast Series. This episode is titled, Obesity Across the Spectrum on Heart Failure.

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00:00:19.700 --> 00:00:21.610
Celeste Chavez: Who do we treat, and how?

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00:00:22.500 --> 00:00:31.409
Celeste Chavez: This program has been created and directed by the Volunteer Planning Committee and is made possible by the support of Bayer.

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00:00:32.729 --> 00:00:37.129
Celeste Chavez: I'm Celeste Chavez, and I'll be introducing today's discussion.

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00:00:37.360 --> 00:00:42.580
Celeste Chavez: I'm a nurse practitioner from Sutter Health Palo Alto Medical Foundation.

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00:00:43.220 --> 00:00:46.229
Celeste Chavez: And I'll ask my colleague to introduce herself.

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00:00:47.190 --> 00:00:59.990
Anu Lala: Hi, Celeste, I'm Anu Lala. I'm a heart failure, I'd like to say heart function cardiologist at the Mount Sinai Fuster Heart Hospital in New York City, and I'm so excited to be doing this with you.

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00:01:01.200 --> 00:01:03.769
Celeste Chavez: So am I. This is gonna be wonderful.

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00:01:04.250 --> 00:01:19.119
Celeste Chavez: Before we get started, it's important to give the disclaimer. The recommendations and opinions presented by the faculty today may not represent the official position of the American Heart Association.

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00:01:19.320 --> 00:01:28.100
Celeste Chavez: The materials are for educational purposes only, and do not constitute an endorsement or instruction by the AHA.

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00:01:28.440 --> 00:01:32.849
Celeste Chavez: The AHA does not endorse any product or device.

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00:01:35.440 --> 00:01:46.409
Celeste Chavez: So let's get started. Obesity isn't just a risk factor. It's a metabolic, inflammatory, and hemodynamic force that shapes the trajectory of heart failure.

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00:01:46.590 --> 00:01:53.640
Celeste Chavez: From asymptomatic diastolic dysfunction to advanced heart failure reduced ejection fraction.

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00:01:54.050 --> 00:02:06.830
Celeste Chavez: So today, we'll explore mechanisms, clinical paradoxes, and emerging treatment strategies, including what the latest trials like SELECT, STEP…

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00:02:07.100 --> 00:02:12.009
Celeste Chavez: heart failure preserved ejection fraction, and EMPULSE are teaching us.

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00:02:12.490 --> 00:02:14.360
Celeste Chavez: Doc… Anu.

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00:02:14.860 --> 00:02:17.700
Celeste Chavez: What does obesity do to the heart?

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00:02:18.660 --> 00:02:29.630
Anu Lala: Thanks so much for asking this. I love that we're having this conversation. You, with your expert nursing background, myself as a physician in the heart function, heart failure space, I think

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00:02:29.630 --> 00:02:44.480
Anu Lala: we all agree that managing heart failure, treating heart failure, preventing heart failure is a team sport, right? So, it's nice that we have this conversation across disciplines today. I think your question is so spot on. What does obesity do to the heart?

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00:02:44.480 --> 00:02:53.669
Anu Lala: I think obesity, and we're recognizing that increasingly so in recent times, particularly visceral adiposity.

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00:02:53.710 --> 00:03:00.400
Anu Lala: Triggers systemic inflammation. It triggers insulin resistance, neurohormonal activation.

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00:03:00.510 --> 00:03:12.920
Anu Lala: And what's so interesting is that adipose tissue is not just dormant tissue, it's really an endocrine organ. It secretes pro-inflammatory cytokines like IL-6,

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00:03:12.920 --> 00:03:21.549
Anu Lala: TNF-alpha, and leptin, amongst others, while reducing factors like adiponectin, which is a protective molecule.

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00:03:21.850 --> 00:03:25.330
Anu Lala: So, in heart failure with preserved ejection fraction.

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00:03:25.620 --> 00:03:38.420

Anu Lala: This contributes to LV concentric remodeling, impaired diastolic relaxation, microvascular dysfunction, and myocardial stiffness by way of all of these other processes.

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00:03:38.580 --> 00:03:39.580
Anu Lala: And so…

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00:03:39.730 --> 00:03:47.870
Anu Lala: What has really been so humbling for me is that there's an increased and now accepted recognition that this phenotype

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00:03:47.890 --> 00:04:03.900
Anu Lala: which is, you know, more commonly observed in middle-aged women with metabolic syndrome, is often coined metabolic heart failure with preserved ejection fraction, or the obese phenotype of HFpEF, which is at least two-thirds of HFpEF.

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00:04:04.370 --> 00:04:21.119
Anu Lala: And I would say, Celeste, I'm sure you see this amongst your patients too, it's not just that obesity leads to HFpEF, right? We know that in heart failure with reduced ejection fraction, obesity still plays a role. It amplifies preload, it promotes eccentric remodeling.

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Anu Lala: It worsens the burden of comorbid conditions like sleep apnea, hypertension, insulin resistance, or diabetes if it progresses to that.

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Anu Lala: So, it's really applicable across the spectrum of…

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00:04:33.980 --> 00:04:43.359
Anu Lala: Heart failure, regardless of ejection fraction, but perhaps in maybe just slightly distinct ways, or at least we're trying to figure out if that is the case.

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00:04:43.430 --> 00:04:53.180
Anu Lala: And I think what's also interesting is we've placed so much emphasis on understanding the pathogenic role of the renin-angiotensin-aldosterone system.

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00:04:53.680 --> 00:05:10.799
Anu Lala: But we also have this adipose renal cardiac access, right? Where obesity-induced glomerular hyperfiltration leads to proteinuria, it leads to chronic kidney disease progression, and volume overload, all of which are key drivers of heart failure progression.

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00:05:11.060 --> 00:05:28.130
Anu Lala: I mean, if you think about, just… and this is for HFrEF, because there's so much emphasis, so much talk about obesity related to HFpEF, right? But if you look at the CHAMP-HF registry, over 45% of patients with heart failure have a BMI of 30 or higher.

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Anu Lala: 30% have Class 2 or Class 3 obesity, so this is a real… it's a real issue amongst our patients who are living with heart failure.

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00:05:38.610 --> 00:05:43.650
Anu Lala: Is that… would you say, Celeste, that this is what you're seeing clinically as well?

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00:05:44.730 --> 00:06:03.110
Celeste Chavez: I'm definitely seeing this clinically as well. You know, we battle with this with our patients, because they struggle with obesity, and they do try to lose, and it's so hard to get out of the cycle of, you know, having excess weight, and changing diet, and lifestyle, and everything else.

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Celeste Chavez: So, …

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00:06:05.090 --> 00:06:22.510
Celeste Chavez: How do you feel this obesity paradox affects the patients? You know, there was… in the OPTIMIZE-HF, in the Get With The Guidelines-Heart Failure, it shows that patients with higher BMI often show short- term better outcomes, but then…

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00:06:22.580 --> 00:06:31.349
Celeste Chavez: after hospitalization, you know, we have to be really careful, because it's just temporary, you know? It's just for… once we dry them out, then…

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00:06:31.450 --> 00:06:38.449
Celeste Chavez: They resort back to, you know, retaining more fluid and just doing poorly over time.

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00:06:38.450 --> 00:06:56.509
Anu Lala: Yeah, Celeste, I'm so glad you brought this up, right? Because this… when I was a fellow, not to date myself, we were sort of obsessed with this obesity paradox, right? It was, oh my god, lower BMI reflects cachexia or frailty, these patients are going to do worse.

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00:06:56.510 --> 00:07:05.710
Anu Lala: You know, obese patients are probably presenting earlier on in their heart failure trajectory. They have more… they're more likely to have better reserve,

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00:07:05.870 --> 00:07:24.390
Anu Lala: We know, that NT-proBNP is artificially lower in obesity, so that can actually lead to delayed diagnoses. And I'm sorry, I didn't complete my thought before, but the idea, really, of this obesity paradox comes from the first two points I mentioned.

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00:07:24.390 --> 00:07:36.489
Anu Lala: around lower BMI indicating cachexia, and lack of reserve. And that was really seen more so in the heart failure with reduced ejection fraction population.

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00:07:36.490 --> 00:07:44.029
Anu Lala: But much of this paradox, I think, we're learning, is due to this confounding, like I was talking

about, where natriuretic peptides

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00:07:44.140 --> 00:08:02.050
Anu Lala: for example, maybe artificially lower, not artificially, but maybe encountered in lower values amongst obese patients. And when you look at longitudinal data, and when you consider the impact of visceral adiposity, this paradox doesn't really hold up.

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00:08:02.240 --> 00:08:10.799
Anu Lala: When you look at, you know, data from MESA, for example, there is this indication of

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00:08:10.970 --> 00:08:14.900
Anu Lala: abdominal fat, not just BMI.

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00:08:14.920 --> 00:08:32.019
Anu Lala: really predicts incident heart failure. So there's, as I was mentioning previously, this recognition of visceral adiposity, particularly abdominal fat, which is where it kind of manifests, as being this… this organ in and of itself.

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00:08:32.110 --> 00:08:34.999
Anu Lala: And I think that…

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00:08:35.230 --> 00:08:44.659
Anu Lala: we have now moved away from taking false, comfort in this idea of the obesity paradox.

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00:08:44.850 --> 00:08:59.719
Anu Lala: I personally, and, you know, of being of South Asian descent, think it's so important for us to move just beyond BMI, but rather using things like waist circumference, body composition analyses, and obviously clinical judgment.

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00:08:59.800 --> 00:09:15.630
Anu Lala: in addition to BMI, to really quantify and qualify whether obesity is playing a role in a patient's trajectory or risk for developing heart failure. What do you think about that? Like, are you seeing…

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00:09:15.670 --> 00:09:24.899
Anu Lala: a really diverse population. I know this is very relevant for the South Asian population, but it's also applicable more broadly.

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00:09:25.870 --> 00:09:37.609
Celeste Chavez: Yeah, we're pretty lucky. You know, I live in the Bay Area, so we have a very diverse population. We have lots of Southeast Asians, we have lots of Asians, we have lots of…

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00:09:38.300 --> 00:09:46.619
Celeste Chavez: African American population, Hispanic, so, you know, we see the breadth of the whole population here, thankfully. …

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00:09:46.890 --> 00:09:52.910
Celeste Chavez: So, we definitely see, what you're talking about. I see it every day in, …

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00:09:53.790 --> 00:10:07.049
Celeste Chavez: it's sometimes a challenge with, you know, these little old women, like this, a 55-year-old, you know, case study would be the example that has Class 3 obesity, preserved ejection fraction.

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00:10:07.090 --> 00:10:19.080
Celeste Chavez: you know, dyspnea, poorly controlled diabetes, this woman is typical, in our practice, and actually even can go up to 85, 90 years old.

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00:10:19.190 --> 00:10:35.999
Celeste Chavez: So, what I see every day is exactly what you're talking about, and it's always a challenge, I think, more with women than men, assessing their volume status, or, you know, how much their obesity plays, because you can't exactly determine

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00:10:36.070 --> 00:10:46.249
Celeste Chavez: their JVP, because their neck is so thick. So it's definitely a challenge, and trying to put it all together, takes a little…

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00:10:46.680 --> 00:10:49.550
Celeste Chavez: Clinical judgment, and a lot of…

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00:10:49.890 --> 00:10:54.559
Celeste Chavez: Assessing, and a lot of just knowing the patient over time.

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00:10:54.760 --> 00:10:59.399
Anu Lala: Yeah, I think you're totally right. You're really emphasizing that clinical judgment, right? Like.

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00:10:59.410 --> 00:11:13.840
Anu Lala: HFpEF is so underappreciated because we are so desperate for just numbers and values and labs to tell us whether someone has a diagnosis or not, right? Like, this 55-year-old woman, you're saying as a case example, she's got

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00:11:13.840 --> 00:11:21.530
Anu Lala: you know, if she's carrying excess weight, BMI, let's say, is 38, she has a preserved ejection fraction, she's poorly controlled diabetes.

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00:11:21.530 --> 00:11:26.510
Anu Lala: ECHO shows, you know, maybe LA enlargement, elevated filling pressures.

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00:11:26.520 --> 00:11:46.140
Anu Lala: But her anti-proBNP is only 80, and you say, oh, well, her dyspnea can't be due to heart failure, this has got to be the fact that she's obese, or she's got poorly, you know, she's not conditioned, and she's poorly controlled diabetes, she's not active. But we have to integrate that with really understanding the patient on a personal level. Is this HFpEF?

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00:11:46.400 --> 00:12:00.419
Anu Lala: likely, you know, you're seeing elevated filling pressure, so it doesn't just have to be the natriuretic peptide. So we really have to kind of assess that physiology and personalize that. So…

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00:12:00.560 --> 00:12:14.409
Anu Lala: I guess the question is, what can we do, right? What are the therapeutic strategies that actually work? What are your… what are your recommendations as a nurse expert as to lifestyle modifications?

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00:12:15.080 --> 00:12:33.400
Celeste Chavez: You know, usually I start with, like, what do they do every day, you know? And it's not one, in my opinion, it's not one thing fits all, you know, so just listening to what they do every day, how do they eat, what do they eat, you know, are they eating tons of salt, are they…

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00:12:33.400 --> 00:12:43.870
Celeste Chavez: you know, not cooking and eating frozen foods, are they eating out every day? You know, how well is their diabetes controlled? Because we all know that that plays a big…

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00:12:43.880 --> 00:12:47.169
Celeste Chavez: Factor in just heart health.

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00:12:47.180 --> 00:13:03.559
Celeste Chavez: In general. So just learning what they do and making small changes, like, at each visit, I think I've learned over time that when I was young in practice, I used to think, oh, I can tell them all these 10 things and they'll change, but

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00:13:03.560 --> 00:13:23.089
Celeste Chavez: I know now that you give them one little change at a time, and you pick the things that are the easiest for them, that they feel they can change. Using… I use a lot of motivational interviewing, in my practice, so that's the way I try and work with them to change, and it's not immediate. It takes

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00:13:23.230 --> 00:13:25.009
Celeste Chavez: Weeks and even months.

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00:13:25.290 --> 00:13:26.700
Celeste Chavez: I love that.

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00:13:27.060 --> 00:13:31.380
Anu Lala: First of all, it sounds a lot like raising children.

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00:13:31.380 --> 00:13:33.749
Celeste Chavez: Definitely like raising children.

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00:13:33.750 --> 00:13:34.249
Anu Lala: But I love….

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00:13:34.250 --> 00:13:35.200
Celeste Chavez: bigger versions.

84
00:13:35.200 --> 00:13:53.660
Anu Lala: Yeah, seriously, right? I really believe, in the power of motivational interviewing, of having the mo… you know, having the impetus to drive change come from the patient, rather than us dictating. You know, they are, as much as I brought up the kids, I'm being facetious, right? These are…

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00:13:53.660 --> 00:14:05.430
Anu Lala: adults, they are faced with their own challenges, and we can't claim to understand everybody's personal situation, but having the motivation arise from them and facilitating that process, I think, is so crucial.

86
00:14:05.430 --> 00:14:15.219
Anu Lala: What about cardiac rehab? Are you universally recommending that? I mean, if you look at HF-ACTION, for example, we saw improvements in 6-minute walk distance and quality of life.

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00:14:15.220 --> 00:14:32.340
Anu Lala: Even if they didn't experience weight loss. So, how often are you doing this? For us, it's always a challenge to have insurance cover it for heart failure with preserved ejection fraction, but we do have a decent time with reduced ejection fraction, particularly on the lower end.

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00:14:32.620 --> 00:14:36.910
Celeste Chavez: Yeah, we're pretty lucky, you know, we have both… …

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00:14:36.980 --> 00:14:39.990
Celeste Chavez: Programs that are covered by insurance.

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00:14:40.030 --> 00:14:55.099
Celeste Chavez: In our area, we have 3, actually, in our area, and then we have a Phase 4, which we tend, for heart failure patients, especially preserved, to send them there. Now, it is out of pocket, so not everybody can afford it, however…

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00:14:55.100 --> 00:15:04.449
Celeste Chavez: This, cardiac rehab is pretty well supported by philanthropy, so if somebody can't afford it, they actually find a way to help them afford it.

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00:15:04.450 --> 00:15:18.620
Celeste Chavez: So we're pretty blessed. So anyone that we feel that can go and, you know, is able to do cardiac rehab, we refer. So a lot of people go to cardiac rehab from our practice.

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00:15:18.620 --> 00:15:23.159
Anu Lala: Celeste, you're just adding to my never-ending list of reasons to move to California.

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00:15:23.160 --> 00:15:24.220
Celeste Chavez: That, like.

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00:15:24.220 --> 00:15:39.740
Anu Lala: your intention. You know, we also know that pharmacotherapy has come so far. I really love, and this is across the spectrum of ejection fraction, right? We know guideline-directed medical therapy, immediately you think about HFrEF.

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00:15:39.780 --> 00:15:51.540
Anu Lala: But we've evolved so much in the HFpEF space, and we're going to hopefully continue to do that. I think with respect to heart failure with reduced ejection fraction, when we talk about

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00:15:51.540 --> 00:16:01.059
Anu Lala: things that can impact obesity, I think we see that SGLT2 inhibitors in DAPA-HF, in EMPEROR-Reduced.

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00:16:01.060 --> 00:16:08.010
Anu Lala: and even EMPULSE in the acute setting, showed benefit regardless of their BMI.

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00:16:08.130 --> 00:16:25.220
Anu Lala: Right? And there may, you know, anecdotally at least, and there's some mixed reports here, SGLT2 inhibitors may have modest weight-lowering effects as well. So I think, you know, so important, there's so much data to support SGLT2 inhibitor use across the spectrum of ejection fraction.

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00:16:25.220 --> 00:16:36.649
Anu Lala: And then, of course, is the newer kid on the block, where I think this has completely humbled and revolutionized our approach to heart failure, which are the incretin-based therapies.

101
00:16:36.650 --> 00:16:41.020
Anu Lala: Right? This is where it gets, I think, very exciting when we talk about the…

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00:16:41.020 --> 00:16:53.879
Anu Lala: the nexus of obesity and heart failure, right? In the STEP-HFpEF study, for example, semaglutide significantly improved KCCQ scores by 7 to 9 points, it reduced inflammation.

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00:16:53.880 --> 00:17:08.199
Anu Lala: via, you know, high sensitivities… high sensitivity CRP, it decreased waist circumference and weight by 13% to 15%, depending on, you know, which populations you were looking at. I think this was a…

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00:17:08.680 --> 00:17:22.840
Anu Lala: kind of a paradigm-shifting moment, right? Because these were just drugs that were thought to be indicated for patients with diabetes carrying excess weight. And now, we saw drugs that were influencing symptoms.

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00:17:22.930 --> 00:17:39.989

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Commented [SG35]: EMPEROR-Reduced
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Commented [SG37]: EMPULSE
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Commented [SG39]: STEP-HFpEF
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Anu Lala: and then structure in patients who were obese and also were living with heart failure. Then, you know, and I know you know these data, but I think this is just so exciting. Then the SELECT trial got released, right? This was semaglutide in obese patients without diabetes.

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00:17:39.990 --> 00:17:45.289
Anu Lala: And this… and, you know, the patients with heart failure were included in this study.

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00:17:45.590 --> 00:17:52.770
Anu Lala: This showed a 20% reduction in MACE, you know, CV death, myocardial infarction, stroke.

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00:17:52.880 --> 00:18:10.800
Anu Lala: And there were also signals for reduced heart failure hospitalizations, especially with those with elevated CRP. And there were patients, like I said, with heart failure with reduced ejection fraction, smaller population, around 8%, and we don't have granular data on them, but 13% with heart failure with,

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00:18:10.800 --> 00:18:24.900
Anu Lala: preserved ejection fraction. So I think, you know, these data, along with, of course, the SUMMIT trial with tirzepatide, this is not just about semaglutide, really kind of have changed the paradigm in… in…

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00:18:25.290 --> 00:18:35.090
Anu Lala: Us thinking about the indication of incretin therapy for our patients with heart failure with preserved ejection fraction and obesity, …

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00:18:35.680 --> 00:18:47.430
Anu Lala: to be on these drugs, regardless of diabetes, I think is where things have shifted. It hasn't made its way, maybe, to guidelines for that indication, but I do think that that is

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00:18:47.580 --> 00:18:48.770
Anu Lala: forthcoming.

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00:18:49.070 --> 00:19:01.620
Anu Lala: What about metabolic surgery, Celeste? Are you recommending patients? I mean, 10 years ago, 5 years ago even, there were referrals to… to bariatric surgery.

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00:19:01.620 --> 00:19:10.070
Anu Lala: And the fear, of course, was, can we get them through anesthesia? Like, is this going to be a viable option for these patients?

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00:19:10.080 --> 00:19:14.860
Anu Lala: Are you referring patients for surgery any longer, or…?

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00:19:15.130 --> 00:19:15.840
Anu Lala: What's your.

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00:19:15.840 --> 00:19:16.530

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Commented [SG43]: SUMMIT
Commented [VM44R43]: implemented
Commented [SG45]: tirzepatide
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Celeste Chavez: Nope.

118
00:19:16.710 --> 00:19:36.499
Celeste Chavez: We aren't… we aren't referring as many patients to surgery, with… with the advent of the newer drugs, you know, because we're seeing really good effects from the, semaglutide's and the tirzepatide's, and even… I mean, we have had some weight loss also,

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00:19:36.580 --> 00:19:39.659
Celeste Chavez: with the SGLT, you know, drugs.

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00:19:40.510 --> 00:19:44.310
Celeste Chavez: Two, so those have helped, and …

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00:19:44.940 --> 00:19:54.320
Celeste Chavez: We fortunately don't have a huge population of the severe obesity that would meet surgical guidelines. But with the, you know.

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00:19:54.440 --> 00:20:08.210
Celeste Chavez: With the advent of these drugs, definitely my patients who were potentially surgical candidates, were able to lose enough that… and continue to lose, which has been a really good thing.

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00:20:08.590 --> 00:20:14.259
Anu Lala: Right. Yeah, I mean, I think, you know, the advent of SGLT2 inhibitors and incretin-based therapies

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00:20:15.060 --> 00:20:33.400
Anu Lala: sort of, confirm, you know, or reaffirm the data that we did see, that bariatric surgery did reduce incident heart failure and CV mortality in those patients with metabolic syndrome, right? And so maybe it's this incretin-based therapies and SGLT2 inhibitors that kind of emerge

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00:20:33.610 --> 00:20:45.320
Anu Lala: alongside other therapies that we'll talk about as a kind of non-surgical combination for the future. It'll be interesting to see how the guidelines are influenced accordingly.

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00:20:46.040 --> 00:20:49.400
Celeste Chavez: Yeah, it will be interesting to see that over time.

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00:20:51.040 --> 00:20:53.140
Celeste Chavez: So, going from…

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00:20:53.270 --> 00:21:01.949
Celeste Chavez: drug treatment to prevention, how do you feel that we can move forward with preventing all of this from occurring?

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00:21:02.560 --> 00:21:07.100

Commented [SG47]: Semaglutide's
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Commented [SG49]: Tirzepatide's
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Anu Lala: Ugh, you literally… this is my favorite topic, and we, …

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00:21:07.480 --> 00:21:20.029
Anu Lala: sort of, you know, lots of information forthcoming here. We have a scientific statement, that'll be coming out from the Heart Failure Society of America and the American Society of Preventative Cardiology to this effect.

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00:21:20.230 --> 00:21:22.089
Anu Lala: But…

132
00:21:22.470 --> 00:21:39.939
Anu Lala: I think we need to focus on prevention, right? There has been… as much as I am so excited about the data that I shared of SUMMIT and of, you know, all these different clinical trials showing efficacy of incretin-based therapies, as well as SGLT2 inhibitors, as we mentioned.

Commented [SG53]: SUMMIT

Commented [VM54R53]: implemented

133
00:21:40.400 --> 00:21:53.900
Anu Lala: we're still seeing that the incidence is rising of heart failure, right? It's estimated by 2030, it's going to be 8 million Americans with… with heart… living with heart failure. By 2050, that's supposed to rise to over 11 million.

134
00:21:53.900 --> 00:22:02.769
Anu Lala: And we've also seen concerning trends with respect to mortality, of it not really continuing to go down, but rather kind of being on the way up.

135
00:22:02.870 --> 00:22:09.070
Anu Lala: And so, it… it really underscores your question, Celeste, of how we need to move

136
00:22:09.240 --> 00:22:21.519
Anu Lala: earlier in the patient's lifespan to focus on prevention. So I think we know, and that's why, just taking a step back, I love the Cardio-Kidney-Metabolic Health Framework.

Commented [SG55]: Cardio-Kidney-Metabolic

Commented [VM56R55]: implemented

137
00:22:21.550 --> 00:22:34.719
Anu Lala: Because it really helps us understand how obesity contributes to Stage A, patients at risk for heart failure, stage B, patients with pre-heart failure.

138
00:22:35.040 --> 00:22:41.469
Anu Lala: But yet, we don't screen for… we don't screen early on enough. We don't risk stratify early on enough.

139
00:22:41.580 --> 00:22:51.339
Anu Lala: I, you know, I think we should be checking for markers of elevated filling pressures, or what, you know, sometimes are referred to as diastolic dysfunction in obese patients with dyspnea.

140
00:22:51.680 --> 00:23:01.229
Anu Lala: confirm it. You may not see it on… check the natriuretic peptides, right? In patients with diabetes and CKD, or diabetes alone.

141
00:23:01.380 --> 00:23:12.659
Anu Lala: an obesity, check albuminuria. Screen for obstructive sleep apnea. Look for, you know, complaints, or when you're seeing someone with polycystic ovarian syndrome.

142
00:23:12.770 --> 00:23:20.395
Anu Lala: think about whether they may be at risk for heart failure. What about metabolic, …

143
00:23:20.970 --> 00:23:38.890
Anu Lala: Liver steatosis. Sorry, the name escaped me, MASLD, right? These are all pointing to the fact that we've become so siloed in our models of care, right? I'm a heart failure specialist, you're a hepatologist, you're a nephrologist, you're an endocrinologist.

Commented [SG57]: MASLD

Commented [VM58R57]: implemented

144
00:23:38.890 --> 00:23:50.329
Anu Lala: But rather, people are whole people, and all the organs are connected, and metabolic syndrome reminds us of that, right? So if you have obstructive sleep apnea, or you have PCOS, or you have MASLD,

145
00:23:50.550 --> 00:24:04.539
Anu Lala: you should be screened for heart failure, right? And so I think what the recognition of the pathophysiologic significance of obesity and heart failure is doing is taking us back.

146
00:24:04.890 --> 00:24:11.970
Anu Lala: To a time where we treated patients more holistically, rather than in siloed models of care.

147
00:24:12.140 --> 00:24:24.579
Anu Lala: So I'm very excited about prevention. I think we need to be very, very proactive rather than reactive to really kind of change and bend the heart failure curve.

148
00:24:24.730 --> 00:24:28.959
Anu Lala: What do you think are some of the barriers to making this happen?

149
00:24:30.040 --> 00:24:48.399
Celeste Chavez: Well, I think you hit the nail on the head. The siloed care that we've become has a big part in it, you know? We don't have enough multidisciplinary clinics that include all the disciplines of, you know, cardiologists, endocrinologists, even obesity medicine, behavioral health.

150
00:24:48.460 --> 00:24:55.640
Celeste Chavez: A nursing team, you know, exercise physiologists, dietitians, you know, we need to all work together

151
00:24:56.000 --> 00:25:09.940
Celeste Chavez: either, you know, we don't have to be all in the same place, but ideally, that would be great, to help patients navigate their health and become more healthy, you know? And even,

152
00:25:10.410 --> 00:25:19.570

Celeste Chavez: addressing kids and their inactivity, you know, because it really starts there, right? All the habits that people have as adults really start

153
00:25:20.180 --> 00:25:37.279
Celeste Chavez: when they're kids and they're not riding bikes anymore, they're riding electric bikes, or they're not going out to play because they're on a computer or playing video games, you know? And then that leads into adulthood, that now we have, you know, people in their 20s and 30s that they sit and play.

154
00:25:37.380 --> 00:25:39.359
Celeste Chavez: Video games, and they're not active.

155
00:25:39.640 --> 00:25:55.349
Anu Lala: Yeah, I mean, you're… you're getting at how can we engage with people in the community? How can we engage with community health workers to allow patients to be more conscious of Life's Essential 8, right?

Commented [SG59]: Life's Essential 8

Commented [VM60R59]: implemented

156
00:25:56.010 --> 00:26:01.320
Anu Lala: Are you exercising? Are you getting that 150 minutes of moderate activity a week?

157
00:26:01.320 --> 00:26:05.530
Celeste Chavez: Are you sleeping well? And I'm guilty of that this week, coming off of service.

158
00:26:05.530 --> 00:26:23.080
Anu Lala: But… but are you… are you eating a diet that is rich in fruits and vegetables? Are you monitoring blood pressure? Are your lipids controlled? Are your sugars appropriate? Right? Is your psychological health being addressed? Your behavioral state? I think…

159
00:26:23.360 --> 00:26:42.530
Anu Lala: Life's Essential 8 are… they are applicable across the spectrum. Whether you're at risk for heart failure, or whether you have heart failure, I think we need to keep in mind healthy lifestyle practices, and really make it a priority, not just a kind of ancillary statement for our patients. Like.

160
00:26:42.740 --> 00:27:01.220
Anu Lala: And I think obesity underscores that more than anything. Like, if you had a heart failure patient, or a patient living with heart failure who had uncontrolled hypertension, you're gonna treat it, right? You're gonna up their Sacubitril-Valsartan, or, you know, whatever other medications are needed. So how could we then overlook obesity?

Commented [SG61]: Sacubitril-Valsartan

Commented [VM62R61]: implemented

161
00:27:01.320 --> 00:27:06.550
Anu Lala: Which is such an important, disease entity in and of itself.

162
00:27:07.090 --> 00:27:22.200
Anu Lala: So, what are your… what are your, sort of, takeaways from this conversation? I've so enjoyed speaking with you, and I'm so, so grateful, I have to say, for our nursing colleagues who we get to take care of patients with, because I truly believe that

163

00:27:22.260 --> 00:27:32.559
Anu Lala: It's a team sport, it's a multidisciplinary sport, and … or not sport, but privilege, really, to take care of these patients together.

164
00:27:33.440 --> 00:27:51.229
Celeste Chavez: Well, I agree with you. I think it is a team sport to take care of these patients, because we can't do it alone. We need each other, and our expertise, and our, you know, wisdom that we belong… that we bring to us to the table. So, it is important to have a team there to take care of these patients, you know?

165
00:27:51.230 --> 00:28:00.659
Celeste Chavez: Obesity is a big driver in heart failure. It's not just a comorbidity. You know, it's a paradox, and it reflects

166
00:28:00.700 --> 00:28:04.530
Celeste Chavez: … different diagnostic limitations.

167
00:28:04.590 --> 00:28:18.130
Celeste Chavez: In how we diagnose things, in how we treat patients. And, we now do, thankfully, for, you know, have new drugs in the…

168
00:28:18.190 --> 00:28:26.150
Celeste Chavez: In our armamentarium toolbox, you know, to treat these patients, to help with the obesity, to help with… …

Commented [SG63]: armamentarium

Commented [VM64R63]: implemented

169
00:28:26.460 --> 00:28:39.450
Celeste Chavez: their heart failure, and then most importantly, in my opinion, is how they live. You know, their lifestyle is a big part of how they take care of themselves and their heart health.

170
00:28:39.500 --> 00:28:57.879
Celeste Chavez: And you know, starting early with children, teens, is so important, and teaching them how to live healthily, you know, but we also know that there is inequity in where kids live, and what's available, and…

171
00:28:58.010 --> 00:28:59.030
Celeste Chavez: …

172
00:28:59.640 --> 00:29:12.170
Celeste Chavez: There's definitely populations who don't get what they need, because they live in a, you know, food desert, and they don't have access to the same care as other people.

173
00:29:12.260 --> 00:29:25.989
Celeste Chavez: So I think that there's still work to be done, you know? I think our guidelines are getting better at addressing some of those things, thankfully, to bring awareness to the issues at hand.

174
00:29:25.990 --> 00:29:35.119
Anu Lala: Yeah, I'm emphasizing prevention, as you said, so I couldn't agree… I couldn't agree more, and thank you so much for engaging in this conversation with me.

175
00:29:35.120 --> 00:29:47.109
Anu Lala: This is a reminder that this episode is a part of the American Heart Association's Heart Failure Podcast Series. More episodes can be found at learn.heart.org. Thanks so much for joining us.

176
00:29:47.140 --> 00:29:48.560
Anu Lala: Thanks so much, Celeste.

177
00:29:48.970 --> 00:29:50.170
Celeste Chavez: Thank you, Anu.